

Chapter DCF 37

APPENDIX A

INFORMATION FOR FOSTER PARENTS FACE SHEET

Date of Placement: ____/____/____

Child's Name: _____ DOB: ____/____/____	Nickname(s): _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female SS#: ____-____-____
Cultural Identification (as indicated by child if old enough): Height: _____ Weight: _____ lbs. Religious Preference (of child or family): Physical Characteristics (e.g., scars, tattoos, birthmarks, discolorations):	

Child's Social Worker With Whom Foster Parent Will Have Contact: Name: _____ Title: _____ Agency: _____	
Agency Secondary Contact (if social worker not available): Telephone: Regular Hours: (____) _____ After Hours: (____) _____	

Reason(s) for Placement	
<input type="checkbox"/> Delinquent Act(s) <input type="checkbox"/> Assaultive <input type="checkbox"/> Non-Assaultive	Nature of Offense(s):
<input type="checkbox"/> CHIPS, other than CAN	Type of CHIPS:
<input type="checkbox"/> CAN <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Neglect	Relationship of Alleged Perpetrator(s) Does the child exhibit any inappropriate sexual behaviors?
<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Physical Handicap <input type="checkbox"/> AODA <input type="checkbox"/> Emotional Disturbance (note related behaviors, e.g., fire starter) <input type="checkbox"/> Learning Disability	

This is a: <input type="checkbox"/> Voluntary Placement <input type="checkbox"/> Court-ordered Placement
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Medical Assistance #:	
Insurance Company (if any): Name _____	
Telephone: () _____	
Policy #: _____	Group #: _____
Physician: _____	Type: _____
Address: _____	
Telephone: () _____	
Dentist: _____	
Address: _____	
Telephone: () _____	
Other Health Specialists/Therapists	
Name: _____	Telephone: () _____
Specialty: _____	
Name: _____	Telephone: () _____
Specialty: _____	
Preferred Hospital: _____	
(Note: Use of hospital may be dictated by insurance company/plan)	

Is foster parent expected to participate in therapy with the child? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name of ☐ Birth Mother:
 Child's ☐ Stepmother:
 (Check most appropriate one) ☐ Adoptive mother:
 Address: _____
 Telephone: () _____

Name of ☐ Birth Father:
 Child's ☐ Stepfather:
 (Check most appropriate one) ☐ Adoptive father:
 Address: _____
 Telephone: () _____

Child's
 Siblings:

Name: _____ DOB: ____/____/____ Phone: () _____
☐ At home ☐ Out of home (where: _____)
 Name: _____ DOB: ____/____/____ Phone: () _____
☐ At home ☐ Out of home (where: _____)
 Name: _____ DOB: ____/____/____ Phone: () _____
☐ At home ☐ Out of home (where: _____)

Significant Extended Family Members (Name, Phone and Relationship):

Legal Custodian: _____
 Relationship: _____
 Address: _____ Phone: () _____

GAL*/Legal Counsel: _____
 Address: _____
 Telephone: () _____

*Guardian ad litem

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WISCONSIN ADMINISTRATIVE CODE

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Significant individuals who may be having contact with the child:			
<u>Name</u>	<u>Phone</u>	<u>Relationship</u>	

Individuals whose contact with the child is forbidden or restricted (e.g., supervised visitation)			
<u>Name</u>	<u>Relationship</u>	<u>Type of Restriction</u>	<u>Rationale (e.g., court order, parents' wishes)</u>

(Should you have any questions about contacts, please call the child's social worker.)

Previous Placements (If no court order prohibiting release of name of previous foster home placement(s))		
<u>Type (FH, GH, RCC/CCI, hospital, etc.)</u>	<u>Name</u>	<u>Dates</u>

School Attending or Will Attend: _____	
Telephone: (____) _____	Grade: _____
Is child enrolled in a special education program? ____ Yes ____ No	
If yes, what type: _____	
Contact Person: _____	

Day Care or Respite Provider(s)	
_____	Phone: (____) _____
_____	Phone: (____) _____

Does the child have specific hobbies or interests? Does the child have special abilities/talents (e.g., music, art, athletics)?
Does the child prefer group or solitary activities?

Does the child have preferences that the foster parent may want to know about (e.g., favorite foods, clothing, toys, music)?

Placing agency has given the foster parent:

- | | | |
|--|---|--|
| <input type="checkbox"/> Birth certificate (copy),
if available | <input type="checkbox"/> Medical records/summary | * <input type="checkbox"/> Social history/summary |
| * <input type="checkbox"/> Court order | <input type="checkbox"/> Permission to operate
hazardous machines | <input type="checkbox"/> Social Security Card |
| * <input type="checkbox"/> Court report/summary | <input type="checkbox"/> Placement Agreement | * <input type="checkbox"/> Summary of social/
psychiatric evaluations |
| * <input type="checkbox"/> Dental records/summary | * <input type="checkbox"/> School academic
records/summary | |
| <input type="checkbox"/> Information on child's
specific diagnosis and/or
disability | <input type="checkbox"/> School and community
activity permissions | <input type="checkbox"/> Summary of mental
health treatment |
| <input type="checkbox"/> MA card | <input type="checkbox"/> Signed medical release
for emergency health
care | |

* Summary is requested to ensure that materials (e.g., psychological assessments) can be interpreted by foster parents.
Primary source documents can be provided if useful for clarification.